STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLANA SENIOR LIVING, LLC	7721 BATTERY POINTE WAY INDIANAPOLIS, IN 46240

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R000000	This visit was for the Investigation of Complaint IN00157379. Complaint IN00157379 - Substantiated. State deficiency related to the allegation is cited at R0242. Survey Dates: October 9 & 10, 2014 Facility number: 013164 Provider number: 013164 AIM number: NA Survey Team: Mary Jane G. Fischer RN TC Census bed type: Residential: 30 Total: 30 Census payor type: Other: 30 Total: 30 Sample: 8 This State finding is cited in accordance with 410 IAC 16.2-5. Quality Review was completed by Tammy Alley RN on October 15, 2014.	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R000242	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on record review and interview the facility failed to ensure notification of continued medication administration in regard to anticoagulation therapy and the display of bruising without resolution and hematuria for 1 of 3 residents on anticoagulation therapy in a sample of 8. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 10-09-14 at 10:00 a.m. Diagnoses included, but were not limited to, congestive heart failure, atrial fibrillation and hypertension. These diagnoses remained current at the time of the record review. The resident had physician orders originally dated 07-11-14, for Warfarin Sodium (an anticoagulant) 5 mg (milligrams) orally once a day.	R000242	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. R242 Health Services With regards to finding R242 Health Services Solana SeniorLiving, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** Clinical record for resident A was audited. A meeting was held with Resident A's Doctor and future service plan was discussed and therapeutic INR range will beestablished for resident upon return to community. ***How will you identify other residents having the potential to be affected by the same finding***	10/31/2014

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	A review of the Nurse's Notes indicated the following: "09-05-14 - 8:20 a.m., Call to resident room to look at urine in urinal. Urine was brown in color. Resident was sitting on toilet and voided with visible blood. Call made to [name of nurse practitioner] regarding findings - left VM [voice mail]. 8:45 a.m., Spoke with [name of nurse practitioner] new orders received as follows: D/C [discontinue] Zaroxolyn [a diuretic medication] 5 mg, increase Hydrochlorothiazide [a diuretic medication] 40 mg one tab by mouth every day. 12:30 p.m., Urine specimen obtained placed on ice. 2:00 p.m., Clarification received as follows: Hydrochlorothiazide 50 mg one tablet by mouth every day. 8:30 p.m., Res. [resident] continues to have hematuria. Fluids enc. [encouraged] no c/o [complaints of] voiding. 8:30 a.m., addendum - Urine specimen awaiting pick up in A.M." "09-07-14 - 8:05 a.m., Urine specimen has been picked up by lab." "09-08-14 - 6:00 a.m., No hematuria noted. Awaiting lab results." "09-09-14 - 5:45 a.m., Res. continues with quarter sized bruise to lower back.		***and what corrective action will be taken:*** Clinical Records of all residents receiving anticoagulation therapy were audited and found in compliance. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** A therapeutic INR range will be established by MedicalDirector/Residents Physician for each resident receiving anticoagulation therapy. Nursing staff will implement ananticoagulation therapy flow sheet for all resident's receiving anticoagulation therapy. Conduct in-service for all licensed nurses and QMA's on the policy and procedure for anticoagulation therapy side effects, condition change and documentation. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Clinical Director or designee will utilize an audit tool for all resident's receiving anticoagulation therapy. Clinical Director or designee will audit 1 x week for 3 months, 2 x per month for 3 months. If no issues are identified then monthly audits thereafter. ***By what date the systemic changes will be completed:*** October 31, 2014	

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	No noted c/o pain or discomfort voiced or displayed. No s/s [signs or symptoms] of odor or hematuria noted this shift. 10:00 a.m., Resident continues with bruise to lower back purple to red in color. Quarter size." "09-10-14 - 5:45 a.m., Resident continues with bruise to lower back purple in color. 12:00 p.m., Resident continues with bruise to lower back Red to purple in color. 10:00 p.m., Bruise noted to lower back skin intact area purplish - red." "09-11-14 - 5:00 p.m., Resident continues with bruise to lower back red on color." "09-15-14 - 1:00 p.m., Called to resident's room to look at urine voided. Noticeable blood in urine. Urine appeared red in color. No pain or discomfort was experienced by resident. Call to NP [nurse practitioner] left VM. Encouraged fluids. 3:15 p.m., Res. called CNA [certified nurse aide] to room. Writer alerted that res. was on floor. Res. found sitting on buttocks on floor with buttocks against left side of recliner. Denies hitting head. Denies pain. 5:10 p.m., NP notified of res. fall." "09-16-14 - 12:30 p.m., New order: Lab CBC [complete blood count] with			

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	differential, BNP [B-Type natriuretic peptide blood test] dx. [diagnosis]: Congestive heart failure. 7:15 p.m., Res. transferred self to recliner. Res. did not seem to remember recent falls since admission to facility. Bilat. [bilateral] bruises noted to bilat. knees with right side being larger." "09-17-14 - 10:00 p.m., CNA reported during transfer of resident from chair to w/c [wheelchair] - resident had to be lowered to floor to prevent fall d/t [due to] resident refusing to bear wt. [weight]. No injuries noted." "09-18-14 - 10:15 a.m., Bruise noted to lower right back. Red in color. Circular shape. 7 cm [centimeters] by 9 cm measured. 1:00 p.m., resident continues on Coumadin [an anticoagulant] therapy every day which causes resident to bruise easily. 9:30 p.m., Bruise noted to right lower back, purplish red." "09-19-14 - 7:00 a.m., Bruise still remains on lower back. Red and purple in color. 12:00 p.m., Bruise remains to right lower back. Red, circular. 8:00 p.m., Dk. [dark] purplish bruise noted to right lower back ... has had fall on 09-15-14." "09-20-14 - 5:00 a.m., Bruise remains to			

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	right lower back. Bruise red on color." "09-28-14 - 10:45 a.m., Resident urinating bright red blood with small clots - also c/o discomfort when urinating. NP informed. Will push fluids and offer cranberry juice d/t previous history. 2:55 p.m., Received call from NP and notified of blood in urine. New order to send urine for ua [urinalysis] c & s [culture and sensitivity] and push fluids." "09-29-15 - 5:45 a.m., Received report form evening shift at 11:00 p.m. Evening shift stated that resident had blood in urine. Evening shift nurse stated that she made call out to NP notifying her of blood in urine. Telephone order was given to send urine for ua c & s. At around 5:45 a.m. CNA went into res. room to check on res. CNA called this writer to res. room When entering room this writer notice a moderate amount of blood on sheets. This writer checked to see where it was coming from and notice it was coming from penis a small amount. This writer made call out to Clinical Director to inform that I was going to send res. out to the hospital. Clinical Director stated that the NP was already aware of the situation and had orders in place and that there was no need to send res. out to the hospital and to give			

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	the res. plenty of fluids. 8:15 a.m., Called to residents room by aide. Upon arrival aide noted that resident sheets have been saturated in blood, including resident's pull up. Aide states during shower a constant flow of blood released from penis. Resident c/o slight discomfort. 8:20 a.m., Call to 911 requesting ambulance. 8:25 a.m., Call to NP. Left voice mail. 8:30 a.m., Fire Department arrives. 8:40 a.m., Ambulance arrived transporting resident to hospital. 8:00 p.m., Notified per [name of local area hospital] res. admitted with diagnosis of hemorrhagic cystitis, renal insufficiency, dehydration, increased INR and altered mental status." A review of the urinalysis, obtained on 09-07-14, indicated the "color - light brown, cloudy in appearance, with bacteria too numerous to count and 4+ blood." A review of the resident's Medication Administration Record, dated September 2014, indicated the resident received the anticoagulant daily from the first time blood was observed in the resident's urine, 09-05-14 thru 09-28-14. A review of the PT (prothrombin time) / INR (International Normalized Ratio) results indicated the following:			

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"08-29-14 PT 38.6 (normal range 9.5 - 11.8) - INR 3.2 (normal range .9 - 1.1)."

"09-08-14 PT 37.5 - INR 3.1."

"09-23-14 PT 46.4 - INR 3.8."

A review of the Hospital record indicated, "Resident on coumadin therapy, presents with hematuria that pt. [patient] states has been present that past week. He does report dysuria for the past 2 - 3 weeks. Pt. has supratherapeutic INR of 4.75. Pt. received 2 - 250 ml [milliliters] NS [normal saline] bolus, KCL [potassium chloride] 40 MEQ [milliequivalent], Cefazlin [an antibiotic] 1 gram, Phytonadrone [vitamin K - a medication to aide in clotting] 2 grams in ED [emergency department] and 2 mg of Vitamin K. Impression/Assessment: 1. Hematuria likely GU [genitourinary] bleed secondary to increase INR, 2. Supratherapeutic INR (INR 3.8 week ago), 3. Acute blood loss."

During an interview on 10-10-14 at 10:15 a.m., the Nurse Practitioner indicated she was out of town at a conference from 09-25-14 thru 09-30-14. "I took some of my calls but [name of Medical Director] was my back up. I don't remember getting that result because I would have

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	stopped the Coumadin for a day or two." A review of the facility policy on 10-10-14 at 9:10 a.m., titled "Resident Change of Condition," undated, indicated the following: "Policy: It is the policy of this community that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriated, timely and effective intervention occurs." "Procedure - 1.) Life Threatening Change - b. The Nursing staff will inform the attending physician of resident status as soon as possible before, during, or after the change of condition occurs or when resident crisis has been managed, and document the notification. d. All nursing actions, physician contacts and resident assessment information will be documented in the nursing progress notes. e. The Clinical Director and General Manager will be notified immediately of life threatening changes of condition." "2. Acute Medical Change - a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a			

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	request for physician visit promptly and/or acute care evaluation. The nursing staff will notify the physician. b. If unable to contact the attending physician or alternate physician in a timely manner notify the "Medical Director" of the community for medical intervention." "3. Routine Medical Change - a. All symptoms and unusual signs will be communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. f. Document resident change of condition and response in the nursing progress notes if necessary. Documentation notes will include time and family/physician response." This State tag relates to Complaint IN00157379.			